ROCK RIVER COMMUNITY CLINIC
FORT ATKINSON • JEFFERSON • WATERTOWN • WHITEWATER

Completed by _____
Date _____
Facility Location _____

Patient Financial Screening Form

Guarantor Information (Parent or Guardian)			
Last Name	First Name		Middle Initial
Mailing/Street Address	City	State	Zip Code
Phone Number	Email	Birth Date	Family Size
Other Phone Number	Relationship to you	Can we leave a message at these numbers? ☐ Yes ☐ No	
Insurance ☐ Medicaid (MA/BadgerCare) ☐ MediCare ☐ None ☐ Other-Insurance Name/Type: _____			

Household Information
List the name, relationship, insurance and DOB of all household members.

Name	Relationship	Date of Birth	Insurance

Type of Income Received by Household (18 and older)

Source of Income	Applicant	Partner	Other	Applicant	Partner	Other
Job Salary/Wages	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No			
Work Location	Employer Name: Employer Address: Length of employment:					
	Employer Name: Employer Address: Length of employment:					
Unemployment	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
Social Security/Disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			

Office Use Only

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Action	Comments	Initial & Date
Verified Household Income		
Verified Number in Household		
Verification Documents Viewed		
Medicaid Eligibility		
Tier	0 1 2 3 4	
Application Date		
Expire Date		
Alias Name (ex. work name)		

Documents presented by patient

- ☐ 1040 tax form from the previous year
- ☐ Copy of month's pay checks
- ☐ Copy of unemployment checks
- ☐ Copy of annual Social Security benefits letter
- ☐ Letter from employer containing salary or hourly wage
- ☐ Letter of support
- ☐ Other (list) : _____

Other forms of income may include, but are not limited to:

- Pension
- Alimony/Maintenance
- Child support
- Disability
- Retirement
- Rental Property Income
- Unemployment
- Veteran's Benefits
- Social Security
- Workers Compensation
- Support from friends or relatives

If patient is eligible for any government assistance, do they want to apply and would they like assistance?

Any additional notes: _____

_____

_____

I hereby certify that the above information is, to the best of my knowledge, correct and true. I am aware that this application requires me to **provide documentation within 30 days** of the signature date below for proof of income. **Sliding fee payment for all services is due and payable at the time of service**. I understand that I must call if any changes occur from the information given on the application. I am aware that **eligibility lasts up to one year** (if there are no changes to income or household size).

Signature of Applicant _____ **Date** _____

I hereby certify that I am denying the sliding fee discount. I acknowledge the sliding fee discount is available to me should I request it.

Signature of Applicant _____ **Date** _____

01/14/25 DM